



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

May 29, 2012

Ms. Judy Peterson, Administrator
Central Vermont Home Health & Hospice
600 Granger Road
Barre, VT 05641-5369

Dear Ms. Peterson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 25, 2012**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota".

Pamela M. Cota, RN, MS
Licensing Chief



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/25/2012
NAME OF PROVIDER OR SUPPLIER CENTRAL VERMONT HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANGER ROAD BARRE, VT 05641	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS	L 000		
L 508	<p>418.52(b)(4)(i) EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON</p> <p>The hospice must: (i) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator;</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review the hospice failed to assure that an injury of unknown source was reported immediately by Hospice employees to Hospice administration for 1 applicable patient. (Patient # 9) Findings include:</p> <p>1. Per review on 4/23/12, a home visit note states "Patient c/o (complaining) of sore thumb/Right wrist (pain).....It seems likely that patient hit his hand on the side rail but was not witnessed.....".</p> <p>Per review of a Case Conference note which waas shared during the Interdisciplinary Team on 3/13/12, the nurse reports: 'Patient has had an increase in pain due to an "apparent injury " of his</p>	L 508		

*POC accepted 5/29/12
Dawn Chittenden / Frances H. Kier*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
CMS NO. 0935-0101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471502	DOES MULTIPLE CONSTRUCTION A. BLDG. _____ B. WING _____	DATE SURVEY COMPLETED 04/26/2012
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NAME OF PROVIDER OR SUPPLIER CENTRAL VERMONT HOME HEALTH HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 CHAMBER ROAD BARRE, VERMONT 05641
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LINE ITEM	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by FULL ARABIC NUMBER OF DEFICIENCY AND LOCATION)	DO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (Each corrective action should be preceded by FULL ARABIC NUMBER OF DEFICIENCY AND LOCATION)	DATE COMPLETION DATE
L-008	<p>RIGHTS RESPECT FOR PRIVATE PERSON</p> <p>The hospice must ensure that all residents receiving services are treated with respect for their privacy and physical status, including injuries or unknown sources of contamination, and that property belonging to residents is protected. All incidents, including those occurring in the hospice, are reported immediately to hospice employees and contracted staff to the hospice administrator.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review the hospice failed to ensure that all incidents of unknown source were reported immediately by hospice employees to hospice administration for applicable patient.</p> <p>(Patient # 0) Findings include:</p> <p>1. Per review on 4/23/12, a home visit note states "Patient c/o (complaining) of sore thumb/right wrist (pain).... It seems likely that patient hit his hand on the side rail but was not witnessed...."</p> <p>Per review of a Case Conference note which was shared during the interdisciplinary team on 3/13/12, the nurse reports: "Patient has had an increase in pain due to an "apparent injury" of his</p>	L-008		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: CEO DATE: 5/2/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continue program participation.

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L 508	Continued From page 1 RUE (right upper extremities),wrist and fifth finger are swollen and bruised.' On 3/14/12 a nursing visit note states "Right wrist and fingers remain swollen and bruising is now more evident...." On 3/15/12 a nursing visit note states "Uncontrolled pain in wrist". Because the source of the injury was unobserved and could not be explained by the patient and the injury could be suspicious due to the significance of the injury (and the vulnerability of the 93 year old patient) an investigation should have been conducted. Per interview at 3:10 PM on 4/23/12, the Hospice nurse who identified the injury confirmed s/he had failed to contact Hospice administration regarding Patient # 9's injury. Per interview on the morning of 4/25/12 both the Hospice Clinical Manager and the Clinical Director were unaware of Patient # 9's injury and confirmed it would be the responsibility of the nurse to report the injury via the agency's Occurrence Reporting process so an internal investigation could be initiated.	L 508			
L 510	418.52(b)(4)(iii) EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON [The hospice must:] (iii) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; This STANDARD is not met as evidenced by: Based on interview and record review, the Hospice agency failed to report an injury of unknown origin for 1 of 13 residents (Resident # 9) to the State Agency within the time frames required by 33 V.S.A., 6903. Findings include:	L 510			

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L 510	Continued From page 2 Based on staff interview and record review, the Hospice agency failed to report to the Adult Protective Services (APS), as required, an injury of unknown origin sustained by a 93 year old patient receiving Hospice services and also receiving care by an agency not contracted with Hospice. Per review on 4/23/12, a home visit note states "Patient c/o (complaining) of sore thumb/Right wristIt seems likely that patient hit his hand on the side rail but was not witnessed.....". Per review of a Case Conference note which was shared during the Interdisciplinary Team on 3/13/12, the nurse reports: " Patient has had an increase in pain due to an "apparent injury of his RUE (right upper extremity),wrist and fifth finger are swollen and bruised. On 3/14/12 a nursing visit note states "Right wrist and fingers remain swollen and bruising is now more evident....." A 3/15/12 nursing visit note states "Uncontrolled pain in wrist". Because the source of the injury was unobserved and could not be explained by the patient and the injury could be suspicious due to the significance of the injury and the vulnerability of the 93 year old patient, an investigation should have been conducted and the injury reported to Adult Protective Services (APS) . Per interview at 3:10 PM on 4/23/12, the Hospice nurse who identified the injury confirmed s/he had failed to contact Hospice administration regarding Patient # 9's injury and failed to contact APS within 48 hours, as required per State Statute 33 V.S.A., 6903.	L 510			
L 545	418.56(c) CONTENT OF PLAN OF CARE	L 545			

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L 545	Continued From page 3 The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: This STANDARD is not met as evidenced by: Based on record review and staff interview the Hospice failed to develop an individualized patient-specific written care plan for 2 of 13 Patients in the sample. (Patient # 4 and # 6) Finding include: 1. Per record review on 04/24/12 of Patient #4 and #6's care plans , (as noted on the 485) it states 'management of infusion device' and 'catheter care'. Per further review, the initial assessments for both patients do not indicate an infusion device nor catheter. Per interview on 04/25/12 at 9:30 AM the Hospice Clinical Manager stated that "this is auto-populated and was not pulled from the list but should have been". S/he confirmed at that time that the care plan was not an individualized patient-specific written care plan.	L 545			
L 546	418.56(c)(1) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (1) Interventions to manage pain and symptoms.	L 546			

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L 546	Continued From page 4 This STANDARD is not met as evidenced by: Based on staff interview and record review, Hospice Agency staff and the Interdisciplinary Team (IDT) failed to effectively manage and respond in a timely manner to 1 of 13 patient's ongoing complaints of pain. (Patient # 7) Findings include: 1. Per record review on 4/25/12, Patient #7, age 100 with a history of arthritis, was assessed on 3/1/12 for ongoing shoulder pain by the Occupational Therapist (OT). At the time of the visit, the OT rated the patient's pain to be 8/10 (moderate/severe) "Pain jumps to 8 when humerus is actively moved to flex to neutral....shoulder capsule appears enlarged....will suggest anti-inflammatory to SN (skilled nurse)". Review of nursing visit notes, includes the following: On 3/1/12 "Right shoulder pain especially with movement"; 3/6/12: "Right shoulder pain.....reports no relief with Vicodin (opioid pain medication) "; 3/8/12: "c/o of shoulder pain.....(patient) reports s/he wants to talk to MD because s/he doesn't think current med is working....." the nurse suggested the patient could increase from 1/2 tablet (of Vicodin) to a whole tablet; 3/16/12: "Taking hydrocodone (Vicodin) twice daily, still c/o shoulder pain....will try heat"; 3/20/12 "Continues to c/o of shoulder pain...using heat with some results. Taking Vicodin twice daily . Will try increase to 3 X daily"; 3/22/12 Continues to complain of shoulder pain....has increased Vicodin to 3 x daily....but does not notice much difference...suggest s/he try Ibuprofen (nonsteroidal anti-inflammatory pain	L 546			

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L 546	Continued From page 5 medication used in the treatment of arthritis) which had been previously recommended by OT. 3 weeks earlier. In addition, communication between the Interdisciplinary Team (IDT) and the assigned skilled nurse for Patient # 7 was noted on 3/15/12. Per the Case Conference note, the nurse reported to the Team "Patient has significant pain in shoulders.....". No recommendations were made by the Team regarding the patient's pain. Other IDT meetings on 3/22, 3/28, 4/5 and 4/12/12 also failed to address Patient # 7's ongoing shoulder pain issues.	L 546			
L 557	418.56(e)(4) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement. This STANDARD is not met as evidenced by: Based on record review and staff interview, Hospice staff failed to assure that the ongoing sharing of information to assist with the care and services provided was occurred consistently for 2 applicable patients. (Patient # 7 & # 4) Findings include: 1. Per record review on 4/25/12, Patient # 7 has a history of Cystitis (an inflammatory condition of	L 557			

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L 557	Continued From page 6 the urinary bladder characterized by pain, urgency and frequency of urination) often requiring treatment with antibiotics. During a skilled nursing visit on 4/9/12, the nurse's visit note states " PT (patient) c/o (complains of) a UTI (urinary tract infection).....going to get ABX (antibiotic)" order from the patient's physician. However, a follow up skilled nursing visit to Patient # 7 on 4/17/12 did not indicate if the patient was being treated with antibiotics, or was continuing to experience symptoms. In addition, the medication orders did not reflect whether the patient received treatment.	L 557			
L 594	2. Per record review on 04/24/12, Patient #4, who lives in a facility setting, had no Hospice care plan in the main chart. Per interview at 8:00 AM on 04/24/12 the facility staff stated that the patient care plan is the facility's but that "probably the Hospice aide has one in the room". Facility staff were not aware of when the Hospice should be notified nor the Hospice plan of care. Per interview on 04/25/12 at 9:30 AM the Clinical Manager and Hospice Manager confirmed that Hospice is responsible to coordinate and integrate a system of communication. 418.64(c) MEDICAL SOCIAL SERVICES Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services. This STANDARD is not met as evidenced by: Based on staff interview and record review the	L 594			

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L 594	Continued From page 7 Hospice agency failed to assure social services were provided in accordance with the care plan for 1 applicable patient. (Patient # 7) Findings include: 1. Per record review on 4/24/12, Patient # 7 was admitted to Hospice for Failure-to-Thrive at the age of 100. During the patient's admission to Hospice on 2/23/12 the Medical Social Worker (MSW) made a co-visit with the nurse to conduct a psychosocial assessment of the patient and family needs. The 2/23/12 MSW's admission note states that Patient # 7 agreed to have MSW visits within 2-3 weeks and the plan of care states the visits will be made at least monthly. As of 4/25/12, 2 months since the initial visit, the MSW failed to follow the plan of care and has not made a visit to Patient # 7 as agreed upon during the admission to Hospice. This was confirmed by the Hospice Clinical Manager on the morning of 4/25/12.	L 594			
L 598	418.64(d)(3) COUNSELING SERVICES (3) Spiritual counseling The hospice must: (i) Provide an assessment of the patient's and family's spiritual needs. (ii) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires. (iii) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability. (iv) Advise the patient and family of this service. This STANDARD is not met as evidenced by:	L 598			

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L 598	Continued From page 8 Based on record review and interview the Hospice failed to provide or facilitate spiritual counseling to meet the need of 1 applicable patient. (Patient # 4) Findings include: 1. On 04/23/12 per the record review Patient # 4 was admitted to Hospice services on 03/08/12. During the initial assessment on admission the nurse wrote 'Chaplain Referral- for life review, just to visit, within 2 weeks'. A Social Worker visit note dated 03/13/12 stated "agrees to clergy referral". Per review of the electronic and hard copy chart there was no indication that there was a visit from the clergy/chaplain. Per interview on 04/25/12 at 11:45 AM the Hospice Manager stated that the expectation would be a visit within the week and the paperwork back to the office in 2 weeks. In addition, since the Chaplain was busy with Graduate school during that time frame the bereavement manager (who was also a spiritual counselor) was available but did not visit. The Hospice Manager confirmed at that time the Hospice failed to provide and/or facilitate spiritual counseling as requested.	L 598			
L 628	418.76(g)(4) HOSPICE AIDE ASSIGNMENTS AND DUTIES (4) Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures. This STANDARD is not met as evidenced by:	L 628			

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L 628	Continued From page 9 Based on observation, record review and interview the Hospice aide failed to report to the registered nurse a change in 1 applicable Patient's condition. (Patient # 4) Findings include: 1. Per an observation on 04/24/12 at 7:00 AM Patient #4 stated "it hurts here, (touching right buttocks) been sore for a few days, must have happened when I hit the toilet seat." During care, the Patient grimaced and complained of pain in the right buttocks, stating it hurts and that 'it's sore'. Per interview at 7:45 AM the Hospice aide stated that changes in condition are supposed to be reported to the Hospice nurse. Per review of the Patient's facility record, the progress note of 04/21/12 states "[patient] reports having missed toilet and sat heavily on bathroom floor". Per review of the Hospice communication notes on 04/25/12 there was no evidence that the Hospice Aide reported injury with pain to the Hospice nurse. Per interview in the afternoon on 04/25/12 the Clinical and Hospice Managers confirmed the Hospice nurse was not notified of the new injury and pain.	L 628			
L 677	418.104(a)(6) CONTENT [Each patient's record must include the following:] (6) Any advance directives as described in §418.52(a)(2). This STANDARD is not met as evidenced by: Based on record reviews and staff interview, the Agency failed to have copies of the Advanced Directives (Living Will and/or Durable Power of Attorney for healthcare) and/or correct	L 677			

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L 677	Continued From page 10 information regarding the Advanced Directives in the chart for 5 of 13 residents in the total sample. (Residents # 1,2,3,4 & 5) Findings include: 1. Per record review on 4/23/12 for Patients # 1, 2, & 3, there were no copies of the Advanced Directives in the patient's charts. This was confirmed by the Hospice Manager on 4/25/12 at 12:15 P.M. 2. Per record review on 4/23/12 for Patients # 4 & 5 there were no copies readily available of the Advanced Directives in the patient's chart. In addition, when the Advanced Directives were found on the second day of survey they contained wrong information. Per review of Patient # 4's home copy folder, who lives in a community facility, contained the Advanced Directive for another resident. Patient # 5's Advanced Directive stated that a family member, the one that signed the admission paper work as the DOPA-HC, however the Advanced Directive showed another person as the acting agent for health matters for this Patient. This was confirmed by the Hospice Manager on 4/25/12 at 12:15 P.M.	L 677			
L 796	418.114(d)(2) CRIMINAL BACKGROUND CHECKS Criminal background checks must be obtained in accordance with State requirements. In the absence of State requirements, criminal background checks must be obtained within three months of the date of employment for all states that the individual has lived or worked in the past 3 years.	L 796			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2012
NAME OF PROVIDER OR SUPPLIER CENTRAL VERMONT HOME HEALTH & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANGER ROAD BARRE, VT 05641		
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L 796	Continued From page 11 This STANDARD is not met as evidenced by: Based on review of employee files, the agency failed to show evidence of completing all required background checks for 1 of 5 employees reviewed. Findings include: Per employee file review, one of five Licensed Nursing Assistant who provides care to hospice patients did not have any record of background checks to determine whether they were on the Vermont Adult Abuse Registry, nor was there evidence that a Vermont Criminal Information check was completed. Per interview on 4/25/12 at 2:05 PM, the Human Resources staff person confirmed that the aide had worked for the agency since 1997, and that there was no evidence in the employee's file that those two required background checks had been completed.	L 796			

Plan of Correction

May 22, 2012

L 508	Injury resolved at time of survey. Pain resolved. Occurrence report completed- RN documented reeducation of private hire caregivers re moving client and injury avoidance.	Agency abuse + neglect reporting system	Educate all Hospice staff including IDT + volunteer staff to report all injuries of unknown origin to SV or HO Adm as soon as discovered.
L 510	as for L508	Agency abuse + neglect reporting system	Voice mail, memo to staff and team meeting discussion to heighten staff awareness of reporting injuries of unknown origin as per 33 V.S.A. 6903
L 545	POC amended for 2 clients identified #4 + #6	Have CM check current POC + orders - on all clients to ensure care plan is individualized, accurate + current.	Edit canned text to remove all interventions that are not generic to all HO clients.
L 546	Pt 7 - pain now controlled to client's satisfaction	IDT standing agenda items and IDT case conference note will include a specific line item for uncontrolled symptoms	Hold staff accountable for review reports of other disciplines through IDT review process and staff performance counselling.
L 557 patient # 7	Verified + entered late entry resolution of UTI on subsequent visit. Counseled staff involved - New RN and per diem RN who were not clear on process.	Staff education regarding hand off and follow-up with focus on new staff. Preceptors will focus on follow-up process.	For Per Diem and new staff SV will review caseload regularly and clients seen. Random checks of per diem and new staff documentation
L 557 patient #4	A printed copy of current Hospice Plans of Care including current orders, meds, and goals will be placed in the facility record for all facility Hospice clients.	All facility hospice clients will have summary of order + meds. CVHHH Staff will be instructed to review this information for accuracy at each nursing visit.	RN visiting facility client will review and update the POC with each visit then sign and date as reviewed.
L 594	Finding was brought to attention of MSW who scheduled + visited client within 2 days of finding. MSW inadvertently neglected to write order. MSW counseled to make sure that orders are written at the time subsequent visits are planned.	Review this MSW's caseload regularly to judge if isolated incident.	Counseled MSW to write orders for subsequent visit at the time as she completes doc of current visit.

Plan of Correction

May 22, 2012

L 598	Per diem staff responsible is not available until June 8 - Performance counseling will be conducted on her return.	Review all clients currently on Hospice service for chaplain referral or referral declined by client/family.	Record will be reviewed each SOC for documentation of referral or decline.
L 628	LNA responsible for not reporting injury received performance counseling.	Discuss with all LNA's the reporting mechanism for injuries to CM or SV at LNA staff meeting on 5/22.	Instruction to LNA's to call - and use appropriate telephony system to document notification of case manager
L 677	1. Educated staff at team meeting to continue to document attempts to obtain Advanced Directive copies. 2. Corrected within 2 days of discovery.	Review all current records for Advance Directives and refer MSW as needed to obtain document or assist client / family in creating document.	Monitor all SOC for evidence of AD or documentation of attempt to obtain AD. Discussed at team mtg. 5/7/12
L 796	Background checks in question were in fact in the file at the time of the survey (copies were faxed to Fran Keeler 5.21.2012 and are enclosed)	Not applicable as no deficient practice actually occurred.	Not applicable or no deficient practice actually occurred.

Plan of Correction

May 22, 2012

Revise IDT case communication note template to include reporting of all injuries of unknown etiology. Add as agenda item to IDT.	Hospice Manager and Hospice Administration	31-May
Rework IDT case communication note to include reporting of all injuries of unknown etiology. Add as agenda item to IDT.	Hospice Manager and Hospice Administration	31-May
IDT will review POC as per CoPs.	Hospice Manager and Hospice Administration	15-Jun
To be discussed and documented as a standing agenda item at IDT.	Hospice Manager and Hospice Administration	31-May
Regular meetings with new staff with focus on follow up practices after each visit during first 3 months of orientation.	Hospice Manager and Hospice Administration	31-May
Assign one Hospice nurse to be case manager for all Hospice clients in facilities to ensure continuity of care- this nurse or designees will review the plan of care with facility staff at each visit.	Hospice Manager and Hospice Administration	30-Jun
IDT will review MSW plans for HO patients.	Hospice Manager and Hospice Administration	immediate

Plan of Correction

May 22, 2012

Monitoring all SOC ongoing.	Hospice Manager and Hospice Administration	15-Jun
Regular discussion at team meetings - reminding CM to document reports from LNA and to have nurse/therapist report to SV if they find injuries that should have been reported by LNA to facilitate follow-up performance counseling.	Hospice Manager and Hospice Administration	22-May
Monitor all Starts of Care for documentation of Advanced Directives or attempts to obtain	Hospice Manager and Hospice Administration	31-May
Not applicable as no deficient practice actually occurred.	Director of Human Resources	Not applicable



**Central Vermont
Home Health & Hospice**
A Century of Caring and Quality